

THE ELITE LASER VEIN CENTER

Date: _____

PATIENT INFORMATION

Name _____ Soc. Sec. No. _____
Last name First Middle I

Home Address _____ City _____ State/Zip _____

Home Phone _____

Work Address _____ City _____ State/Zip _____

Work Phone _____

Cell Phone _____ Email _____

Gender: M F Age _____ Birth Date _____ Single Married

Drivers License # _____ Occupation _____ Employer _____

Emergency contact (not living with you) _____ Relationship _____

Home _____ Cell _____ Work _____

Referred to this Office By: _____

PRIMARY INSURANCE

Insurance company name _____ Subscriber # _____ Group # _____

Company Address _____ City _____ State/Zip _____

Name of subscriber if other than patient _____ Relationship _____

Subscriber's date of birth _____

PLEASE SUBMIT YOUR INSURANCE CARD WITH THIS FORM, SO THE WE MAY MAKE A COPY.

Insurance Company Name _____ Subscriber # _____ Group# _____

Company Address _____ City _____ State/Zip _____

ASSIGMENT OF INSURANCE BENEFITS

I certify that I have insurance coverage with the above insurance carrier(s) and hereby authorize Elite Surgery Center to release to the carrier(s) any information that is necessary to obtain insurance benefits. I assign to Elite Surgery Center all insurance payments for medical services rendered. I understand that I am financially responsible for all charges incurred, whether or not paid by insurance. I acknowledge that I have received a copy of Notice of Privacy Practices of Elite Surgery Center.

Patient Signature _____ Date _____

PRIVACY OF MEDICAL RECORDS

Our physicians and staff are fully and acutely aware of the potentially sensitive nature of the information contained in your medical record. Therefore, we ask that you provide us below with a list of those individuals or parties whom you intend to have access to such information in your medical records, and those whom you do not. Unless you request otherwise, it is our policy to share such information with the following individuals or parties:

1. Your next of kin, usually identified as the emergency contact and/or the person(s) who accompanies you during your office visit(s), spouse, child(ren), and/or parent(s);
2. Your medical insurance carrier and its agents;
3. Your referring physician and his/her staff;
4. The physicians and professionals to whom we make referrals, including the pathologist, radiologist, and anesthesiologist, and their staff.

We CANNOT bill your insurance company and/or collect any money from them on your behalf unless we have your permission to disclose such information to them. Also, the quality of your medical care might be compromised if our physicians do not have your permission to consider your case fully and frankly with other physicians and professionals who are involved in your medical care.

Please acknowledge below that you permit the foregoing individuals or parties to have access to the information contained in your medical records by signing below, and list additional individuals or parties that you permit access to such information.

THE FOLLOWING IS A LIST OF ADDITIONAL INDIVIDUALS OR PARTIES WHO HAVE MY PERMISSION TO ACCESS THE INFORMATION CONTAINED IN MY MEDICAL RECORD (IF THERE ARE NONE, WRITE IN "NONE"):

Your signature (required): _____ Date: _____

Please acknowledge below any individuals or parties that you DO NOT authorize access to the information contained in your medical record by signing below.

THE FOLLOWING IS A LIST OF INDIVIDUALS OR PARTIES WHO DO NOT HAVE MY PERMISSION TO ACCESS THE INFORMATION CONTAINED IN MY MEDICAL RECORD (IF THERE ARE NONE, WRITE IN "NONE"):

Your signature (required): _____ Date: _____

THE ELITE LASER VEIN CENTER

NOTICE OF PRIVACY PRACTICES

(Copies available upon request)

The Notice of Practices describes how the Center will use and disclose your protected health information to provide treatment, to obtain payment, or for other purposes necessary to operate this Center. Your protected health information includes the reason(s) for your admission, the type of care and treatment you may receive, and other information, including demographic information (e.g. your home address, age, gender, and so forth) that may be either necessary or helpful to identify you, or to assist your physician and others to provide necessary medical care.

The undersigned certifies that he/she has been offered a copy of the Notice of Privacy Practices on admission to the Center or on the date of first service provided by the Center, whichever was earlier. The undersigned is the patient, or is the duty authorized representative of the patient.

Patient Name

Patient Signature

Date

Witness